

Letters

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Not reading and signing letters you have dictated

Not signing letters saves time

EDITOR—Shere writes that not reading and signing letters you have dictated may be dangerous, but I disagree with most of what he says.¹ Perhaps some other doctors do not have as many letters to sign as I do: to scrutinise and sign every routine clinic letter would mean that I would no longer be able to keep my head above the paperwork. Dreary work is bearable if it is useful, but what is the return for checking routine letters for the odd spelling mistake? Shere mentions a mistyped drug dose error that could have been lethal. No doctor should base his or her drug doses solely on another doctor's letter, signed or not.

A signed letter is certainly more courteous than an unsigned one, but I hope that general practitioners in my area realise that an unsigned letter was dictated with just as much courtesy, that my stress levels are kept in check by sending unsigned letters, and that unsigned letters will arrive more quickly. I would postulate that what general practitioners really do not like are long and unstructured letters in which it is difficult to pick out essential information such as diagnosis, treatment (lethal or otherwise), and when the next appointment is.

Advice to authors

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We are now posting all direct submissions to our website within 24 hours of receipt and our intention is to post all other electronic submissions there as well. All responses will be eligible for publication in the paper journal.

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Please supply each author's current appointment and full address, and a phone or fax number or email address for the corresponding author. We ask authors to declare any competing interest. Please send a stamped addressed envelope if you would like to know whether your letter has been accepted or rejected.

Letters will be edited and may be shortened.

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I started adding "Please accept unsigned to avoid delay" to my letters five years ago. That was some economy of the truth, I admit. But "Please accept this unsigned to avoid delay and because the prospect of unnecessarily signing 2000 or 3000 letters a year fills me with nausea and will bring on my early departure from the NHS" would not have struck the right tone.

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¹ Shere S. Not reading and signing letters you have dictated is dangerous. *BMJ* 2001;322:992. (21 April.)

Not signing letters means that they get sent out quickly

EDITOR—I gave up signing my clinic letters seven years ago and end them with "dictated but not signed by ...". The main reason I gave up signing the letters was that I have peripheral clinics, which I visit every other week. Initially my letters were typed by secretaries at these clinics and sent back to my base hospital for signing. But it was usually over a week after the clinic before the letters went into the post, and I thought this delay unacceptable. I have excellent secretaries, and I have full confidence in them.

Over 100 patients are seen in my clinics each week. If I spent half a minute reading and signing each letter, that would be about an hour a week—time that, in my opinion, could be better spent. I encourage my trainees to dictate but not sign letters as well. Frequently I see typing errors, but I have not encountered anything dangerous occurring as a consequence in my specialty.

I do not think I am being discourteous to the general practitioners, and I have never had any complaints on the matter. Nor do I think general practitioners are discourteous in sending me such letters, as they are busy people too.

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¹ Shere S. Not reading and signing letters you have dictated is dangerous. *BMJ* 2001;322:992. (21 April.)

Some typed communications are not letters

EDITOR—As a radiologist, I find that much of my dictated output is in the form not of letters but of radiological reports, sometimes as many as 200 a day. Checking and personally signing all these¹ is impractical. One has

to trust the secretarial staff to transcribe one's dictation accurately, and the clinicians to make contact if the sense of the report has become garbled beyond recognition. Nevertheless, I am sure that mistakes occur from time to time.

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¹ Shere S. Not reading and signing letters you have dictated is dangerous. *BMJ* 2001;322:992. (21 April.)

Time for signing letters is surely issue for trusts' management

EDITOR—I am a pathologist, and most of my output is in the form of reports for other parties to read and act on. Despite the high volume of work we ensure that all reports are seen and signed by a consultant before they are sent. This includes supervised reports issued by junior staff. Even an omitted word such as "no" may cause problems, and I cannot rely on busy clinicians to notice mistakes, which may have a profound impact on patient management.

If Powell's workload (see www.bmj.com/cgi/eletters/322/7292/992#EL20, printed above) is such that he is unable to sign his reports, surely this is an issue that needs to be addressed by the management of his trust as a clinical risk management issue.

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Perhaps secure systems could be used

EDITOR—In Sweden the issue of signing your reports¹ has recently attracted attention. A test result suggested cancer was missed, and the treatment was delayed, when the doctor went on holiday and had not signed his report.

For several years it has been mandatory to sign your reports at most hospitals in Sweden. As I am a consultant at different physical locations, it might be several weeks before I return to a hospital and am able to sign letters, which is too long in most cases. I have solved the problem by using a web-based system, which allows me to do all the signing on the internet. My secretary gets my voice file through the internet and then types it. I can then read and sign it, and send the referral back to the referring doctor. All this through a web interface.

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¹ Shere S. Not reading and signing letters you have dictated is dangerous. *BMJ* 2001;322:992. (21 April.)

Like cheques, letters should be signed

EDITOR—To fail to check a letter sent out in your name is the act of a fool. The reason for checking a letter is to ensure that there are neither errors nor inaccuracies in the communication or the clinical information. It is the duty of the referring clinician to ensure the completeness, accuracy, and veracity of the information provided. If the receiving clinician uses the information provided and this information is inaccurate then the patient is clearly placed at risk, as Shere's letter outlines.¹

The excuses for not signing a letter that Shere highlights show poor professional attitudes and, in my opinion, highlight a dangerous risk taking exercise by the referring person. It would be extremely embarrassing to declare that a document was inaccurate and unsigned if one's legal defence depended on that document. The theme raised by Shere also applies to internal communications and the completion of request forms.

If a monetary cheque is invalid until it is checked, signed, and dated then a clinical letter or communication should be viewed similarly. Sign a cheque; sign a letter.

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1 Shere S. Not reading and signing letters you have dictated is dangerous. *BMJ* 2001;322:992. (21 April)

Letters serve as legal documents

EDITOR—Shere writes that not reading and signing letters you have dictated may be dangerous.¹ It may help to put yourself in the recipient's shoes. If you were involved in a court case and your lawyer sent you unsigned and unchecked letters, would you be impressed by his or her professional standards? Yet that lawyer is as busy as you, and, in context, his or her advice is as important.

The use of "pp" and "dictated by" are also spreading in the legal profession, but most lawyers are aware that they are responsible for the accuracy of their correspondence. As a matter of law, signature by an agent (someone expressly authorised by you to do the act on your behalf) often has the same effect as if you had signed with your own hand, unless there is some rule that in the particular context you must sign personally.²

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2 R v Lambeth LBC ex p Crookes (1999) 31 HLR 59.

Signing letters unread is too common

EDITOR—If a letter is sent without the author reading it then say so,¹ but cut out the mushy drivel of the excuse. One of my pet hates is the shower of letters and documents coming to me that have been signed but clearly not

read. Surely this is more dangerous to the signer. Perhaps sending unsigned letters is a way of avoiding being held responsible for the typing errors.

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Nothing seems to have changed since 10 years ago

EDITOR—Shere is right to highlight the danger of letters that are marked "dictated but not signed,"¹ but the impact of airing the issue in the *BMJ* may be less than he hopes. I made precisely the same point in these columns 10 years ago,² but the practice continued unabated. An interesting suggestion was that offending letters should be returned marked "opened but not read."³

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1 Shere S. Not reading and signing letters you have dictated is dangerous. *BMJ* 2001;322:992. (21 April)

2 Doherty J. Followed to the letter. *BMJ* 1991;303:722.

3 Williamson EPM. Followed to the letter. *BMJ* 1991;303:858.

Summary of responses

EDITOR—Shere's letter prompted 31 rapid responses and two letters.¹ People were quick to respond, a third of responses arriving in the first three days after publication. Interestingly, more hospital doctors (18) than general practitioners (7) responded.

Two points came out strongly. Time is clearly of the essence for many doctors, and people wondered who should take responsibility for unsigned letters.

Talking of time, Bernard de Silva said that he is grateful for a telephone call or letter, signed or not. Alistair Tomlinson thinks that the issue is about identifying priorities: "Letters should only be sent if they are correct, but if the time this takes will result in a poorer ... service then other methods should be investigated. Maybe what is really necessary is to encourage more realistic public expectation of what can be expected."

Sri Varman edits all letters that are sent out but admits that some of the letters are signed by a secretary to save time. Christopher Wallace, from Canada, points out that when reviewing a recently dictated letter "[you tend] to read what you think you have dictated and not spot the errors." He solves that by getting important letters and reports proofread by colleagues.

David Carvel reckons that the number of unsigned clinical letters will increase as doctors become busier. "Perhaps we just have to accept what is happening, realising that we are always responsible for our secretaries and software."

Maybe doctors should just get used to sending and receiving unsigned letters. As Shabeer Hussain, in Pakistan, points out, we are getting ever more computer generated

communications in our lives, which do not require signature.

But Andrew Ho, of Los Angeles, suggests a fairly radical solution if doctors are upset by others' work: "If any consultant ... delivers inferior goods at excessive prices then it is irrational for the referrer to renew the contract by continuing to send patients and accepting substandard reports."

Responsibility for the letters concerned many people. If the letter is not read, Emmanuel Ofuasia asks who is liable when a fatality occurs. "Excuses of delays in postage or running satellite hospitals are not acceptable in court when fatalities occur. ... Unsigned documents are unacceptable in the eyes of the law. Whoever 'pps' a letter should be ready to accept the responsibility."

L Reinecke, in South Africa, is surprised that there is any debate about the issue "as every communication, whether in one's clinical notes or letters, may become legal documents in some court case."

Jane Bond, a retired community paediatrician, seconds these thoughts: "It would be sensible for every trust to ensure that each member of staff be reminded of the need to take full personal responsibility for their own correspondence. In particular, there should be a clear code of conduct for medical secretaries which forbids them to 'sign' for others or to dispatch unsigned letters."

Finally, A J Ashworth suggests setting up a trial with those who responded electronically: "We could easily take photocopies of all our letters and examine them for errors. ... We could measure the time taken to review our letters and collect both the evidence of error and the consequence (in time no longer saved) of correcting that error."

Will anyone take this up?

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1 Rapid responses. Not reading and signing letters you have dictated. *bmj.com* 2001;322 (www.bmj.com/cgi/letters/322/7292/992; accessed 3 Aug 2001).

Postpsychiatry

There is nothing postmodern in what people with schizophrenia want

EDITOR—As a social scientist, and as one of a growing number of professionals who can say publicly that they have been treated for schizophrenia, I found the adoption of the term "postpsychiatry" by Bracken and Thomas unsatisfactory.¹ They have fallen under the spell of a current fad, which in psychiatry—as in other disciplines—amounts to the dressing of an emperor in non-existent clothes.

Bracken and Thomas imply that in postpsychiatry's new age the person with mental illness is part of a complex, interacting matrix of social influences in which the mind cannot be abstracted or studied as an independent phenomenon. The individual, it seems, is a creature of his or her social environment. Jaspers's phenomenology of mind is rejected as isolating the individual

from this social matrix. But in my experience, the mind is an independent phenomenon—not merely a system of neuropsychological complexes but the seat of emotion, will, and creativity that transcends the environment.

The most important advances in psychiatry in the modern age are the development of pharmacological treatments that, helping the mind to operate efficiently, can release self reflective energy. Social factors of course are important in the emergence and relapse of illness, but it is our brain that is the author of progress in the network of social relationships.

It is not accidental that many user groups have adopted biological models of schizophrenia. The social psychiatrist Querido reported that patients eagerly accepted his view that voices were caused by a malfunction in brain circuitry, just as we sometimes hear voices on a crossed telephone line. This idea, of symptoms as alien and controllable, is of great comfort for patients and forms the basis of much successful cognitive behaviour therapy. Schizophrenia is not caused by relatives, or by cruel environments. It is an illness like epilepsy that is the subject of misunderstanding and prejudice; an illness of the brain, best treated in ways that allow patients to control symptoms.

Of course, patients and their allies need to address the widespread stigma and prejudice concerning schizophrenia. Active programmes to do this owe nothing to postmodern faddism. Their approach is conceptually similar to that of other campaigns against prejudice concerning minority groups.

What do people with schizophrenia want? They want non-coercive treatments (including pharmacotherapy, cognitive behaviour therapies, and supportive psychotherapy); rapid access to treatments when they experience the onset of symptoms; voluntary admission to hospital when requested; and social work support for housing and employment programmes. There is nothing postmodern in this. True, as Bracken and Thomas assert, community care is failing. It is failing because of government underfunding, not because of a failed model of science. We ask for bread, and you offer us postmodernism.

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1 Bracken P, Thomas P. Postpsychiatry: a new direction for mental health. *BMJ* 2001;322:724-7. (24 March.)

Current psychiatric practice has been exposed

EDITOR—Bracken and Thomas have given a name to the dehumanising biological shibboleth of contemporary psychiatry.¹ Electronic responses serve more to make their case than to refute it: the biologically minded provide no evidence to support their rejection but simply state that Bracken and Thomas are wrong, and recycle

misleading simplifications of earlier challenges to biopsychiatry (the misreading of Laing being a case in point).² To argue that sensitive cross cultural practice is “properly funded” psychiatry³ is, similarly, a form of intellectual appropriation analogous to the hijacking of Tuke’s “moral treatment” by the mad doctors of the 19th century.

To suggest that, in learning disability, postpsychiatry is the norm³ overlooks the sudden emergence of “dual diagnosis,” when psychiatry’s power was threatened by clinical psychology. To believe that non-verbal people with IQs of 45-50 were displaying symptoms of psychosis strains credulity. These are familiar tactics to critics of psychiatry.

That contemporary biopsychiatry, rather than modernist psychiatry, is “bound to unproved ... theories” that fail to “bring around any significant improvement in people’s care”⁴ is shown by the failure of biomedical research to identify any unambiguous sign of psychiatric (as opposed to neurological) disorder in the current *Diagnostic and Statistical Manual of Mental Disorders*, and also by the routine infliction of brain damage on the recipients of psychiatric “care.”⁴ Why do neurologists attempt to control epilepsy? Because seizures inflict brain damage. Why do psychiatrists routinely recommend doctor-induced seizures for depressed people?

Bracken and Thomas have exposed current psychiatric practice. They are prepared to acknowledge that those who hear voices are not necessarily biologically disordered but, rather, are essentially indistinguishable from the “normal” population⁵; that the evidence for supposed brain diseases such as schizophrenia is so self evidently unscientific as to be worthless⁵; that the toxic effects of neuroleptics are widespread and devastating; and that self proclaimed medical texts such as the *Diagnostic and Statistical Manual of Mental Disorders* are driven more by socio-political concerns than by medicine. The manual is more a reflection of contemporary prejudice than it is a psychiatric analogue for *Gray’s Anatomy*.

Critical psychology also questions the pathologisation of misery that biopsychiatry proselytises.⁴ Bracken and Thomas’s article represents a possibility for change. The biological substrate of human conduct is necessary for both ordinariness and madness, but it can never be sufficient explanation for either.⁴

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- 1 Bracken P, Thomas P. Postpsychiatry: a new direction for mental health. *BMJ* 2001;322:724-7. (24 March.)
- 2 Melichar JK, Argropoulos SV. “Postpsychiatry”—or merely “properly funded psychiatry” [electronic response to Bracken et al. Postpsychiatry: a new direction for mental health]. *BMJ* 2001. bmj.com/cgi/eletters/322/7288/724#EL1 (accessed 28 March).
- 3 Barron P. “Postpsychiatry” is psychiatry in learning disabilities [electronic response to Bracken et al. Postpsychiatry: a new direction for mental health]. *BMJ* 2001. bmj.com/cgi/eletters/322/7288/724#EL4 (accessed 28 March).

4 Newnes C, Holmes G, Dunn, C. *This is madness*. Ross on Wye: PCCS Books, 1999.

5 Boyle M. *Schizophrenia: a scientific delusion?* London: Routledge, 1990.

Solution is possible within existing biopsychosocial framework of psychiatry

EDITOR—Bracken and Thomas offer a critique of the practice of modern psychiatry and promise a brave new world called postpsychiatry. But their criticisms of psychiatry are no more than recycled arguments of the antipsychiatry movement; their vision is high on ideals and low on practical utility.

They assume that the legitimacy of modern psychiatry is questionable and that community care has failed, necessitating a new theoretical framework in the post-asylum era. In support of the first notion they quote a book by one of the authors. They ignore evidence against their second argument.¹

Jaspers’s emphasis on the importance of form over the content of psychopathology provokes the authors’ ire. Large cross-cultural studies such as the international pilot study of schizophrenia,² concentrating on the form of symptoms, led to an understanding not only of the universal experience of psychotic symptoms but of social and contextual factors as well. By polarising biological and psychosocial factors, they ignore the rapprochement that has happened recently, as seen in articles by Kandel³ and Holmes.⁴ In their eagerness to portray psychiatrists as social controllers Bracken and Thomas ignore the recent efforts of prominent psychiatrists to defend patients’ rights.⁵

The stated goals of postpsychiatry are alarming. The undue importance of interpretations of subjective experience will divert the focus from the distress and pain experienced by patients. Wrong assumptions may be made in the case of people from immigrant communities, depriving them of effective treatments. It is obvious that all psychiatrists need to be competent in dealing with patients from other cultures. But this is possible within the existing biopsychosocial framework of psychiatry without our resorting to fanciful thinking and recycled ideas.

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- 1 Marshall M, Lockwood A. Assertive community treatment for people with severe mental disorders. *Cochrane Database Syst Rev* 2000;2:CD001089.
- 2 Leff J, Sartorius N, Jablensky A, Korten A, Ernberg G. The international pilot study of schizophrenia: five-year follow-up findings. *Psychol Med* 1992;22:131-45.
- 3 Kandel ER. A new intellectual framework for psychiatry. *Am J Psychiatry* 1998;155:457-69.
- 4 Holmes J. Fitting the biopsychosocial jigsaw together. *Br J Psychiatry* 2000;177:93-4.
- 5 Szmulker G, Holloway F. Reform of the Mental Health Act: health or safety? *Br J Psychiatry* 2000;177:196-200.

Net of exclusion and control is being extended

EDITOR—Bracken and Thomas’s programme for postmodern psychiatry comes at a critical moment of transition in British

psychiatry.¹ But the direction is being moved not by a liberating epistemological shift in approaches to mental disorder but by powerful countervailing voices from a sceptical public and the state. Postmodern perspectives are liable to leave psychiatrists even more vulnerable to a political agenda that is primarily concerned with closure and risk.

The changes driving this transition affect medicine in general. They stem from the disintegration of a previously stable relation between medicine, society, and the state, in which the state supported the right to medical care, medicine delivered treatments to professionally agreed standards, and both gained the respect of an approving society, which secured the political legitimacy of the NHS. The success of this arrangement was underpinned by unquestioned trust in the integrity of the medical profession.

That trust has now begun to unravel, not only among the public but within the government. Complaints about the quality of medical provision, the rise of articulate user groups, and intense media interest in events such as those at Bristol Royal Infirmary have eroded public confidence and politicised standards of medical care. The trend is now away from therapeutic diversity and autonomy towards an unprecedented system of clinical governance "extending into the clinical community at all levels" and open to public scrutiny.²

This applies to psychiatry as well, whose relation to the state is currently the subject of statutory reform. In the case of disorders posing a possible danger to society, a white paper categorically asserts that "concerns of risk will always take precedence" over the patient's "best interests" (para 2.16).³

Control of risk warrants the "move away from the narrow concept of 'treatability'" (para 3.5), which the home secretary believes has allowed psychiatrists too much discretion over whom to detain. In a statement quoted by the Central Office of Information the home secretary said that the white paper changes "this wholly unacceptable position and moves beyond the rather artificial criterion of 'treatability' in determining who should be detained."⁴

The quasilegal category "dangerously severe personality disorder" has been introduced to identify potentially dangerous people who are seldom seen as treatable or detained under the Mental Health Act. General practitioners, social workers, local government officers, and criminal justice agencies will have a statutory obligation to share information with the psychiatric services about such people (para 5.1-3) with a view to detaining those assessed as potentially dangerous, whether they are medically treatable or not (para 3.3).

The postmodern values that Bracken and Thomas advocate are barely acknowledged in this programme of surveillance that extends the net of exclusion, coercion, and control beyond people who are mentally ill and beyond the hospital to the community itself. These moves are opposed

by most psychiatrists⁵ and are an outrage to professionals and user groups who share a humanitarian vision of psychiatric care.

Yet, to those who do not share this view, defence of clinical diversity, tolerance, and patient autonomy can easily appear as an equivocation, if not a wholesale collapse of intellectual and political nerve. Ironically, a more robust assertion of psychiatry's commitment to therapeutic values is needed to contest the gradual assimilation of psychiatry within the criminal justice system. Sadly, the postmodern aversion to fixed ideas and beliefs is no match for a determined agenda of the state.

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1 Bracken P, Thomas P. Postpsychiatry: a new direction for mental health. *BMJ* 2001;322:724-7. (24 March.)

2 Department of Health. *A first class service: quality in the new NHS*. London: DoH, 1998; para 3.12.

3 Secretary of State for Health and Home Secretary. *Reforming the Mental Health Act*. London: Stationery Office, 2000. (Cm 5016-L)

4 Central Office of Information. *Managing dangerous people with severe personality disorder: consultation document*. London: COI, 1999. (22/1/99.)

5 Crawford MJ, Hopkins W, Thomas P, Moncreiff J, Bindman J, Gray AJ. Most psychiatrists oppose plans for new mental health act. *BMJ* 2001;322:866. (7 April.)

Notions of "mad" and "madness" are stigmatising

EDITOR—A little learning is a dangerous thing; this is certainly borne out by the embarrassing spectacle of psychiatrists dabbling in the history of ideas.¹ Bracken and Thomas's trawl of European thought from the 18th to the 21st century, used as a framework for beating up their own profession via their impoverished historical understanding of the development of attitudes towards those who are "mad," left me both disturbed and angry. Disturbed because as a patient I found much of what they said unsettling; and angry because I felt that the evidence used to justify something called postpsychiatry was dangerously flawed.

The Enlightenment philosopher John Locke wrote about the mad that they "do not appear to me to have lost the faculty of reasoning, but having joined together some ideas very wrongly, they mistake them for truths, and they err as men do that argue right from wrong principles." I would say that this is a fair summary of Bracken and Thomas themselves.

Bracken and Thomas state that the Enlightenment (which apparently only ended at the onset of the recent "decade of the brain") somehow promised that rationality and science would overcome human suffering, almost as if this was a bad thing. It seems to me that there is something wonderful and optimistic in this, worth remembering in these more cynical times.

More disturbing to me was the authors' persistent use, in a 21st century context, of the term "madness," as in the "relation between medicine and madness" and "psychiatry's promise to control madness." I have had a mental illness for over two years, but I

am not, and have never been, mad. It is my (perhaps deluded?) understanding that mental illness and madness are not the same thing, and that modern psychiatry is interested in treating mental illnesses. Notions of mad and madness are highly stigmatising. It is sad to see these terms still being used in the psychiatric profession.

The World Health Organisation has identified just one mental illness, depression, as a social and economic time bomb; it is responsible for 4.2% of the world's total burden of disease and the fifth leading cause of disability globally.² This is not the time for the psychiatric profession to show therapeutic cowardice, self indulgence, and self doubt. It would seem that Bracken and Thomas are chasing the tail of their argument around the hermeneutic circle of meaning and thus are going nowhere.

To let the Enlightenment have the last word: the 18th century surgeon, William Cullen, proposed that all pathology originated in a disordered "spasm" of the nervous system. It is my sincere hope that this proposed postpsychiatric project is no more than a tic.

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2 Dawson A, Tylee A. *Depression: social and economic timebomb*. London: BMJ Publishing Group, 2001.

Might "properly funded psychiatry" be better description than postpsychiatry?

EDITOR—Bracken and Thomas seem to believe that the whole of modern biological psychiatry is uncaring, unfeeling, and only willing to see the patient (or, as the national service framework so beautifully puts it, "service user") outside of any social context.¹ We believe that this is a fundamentally flawed view.

Given limited resources and almost no ability to influence social circumstances (how many letters supporting rehousing are successful?), psychiatrists aim to diagnose and treat those elements of a patient's problems that they are able to. The social context plays a great part, but it is a part we unfortunately have very little influence over.

The authors' own example of postpsychiatry (a 53 year old Sikh woman being helped when her psychotic behaviour was explained in cultural terms) could be an example of well funded transcultural psychiatry. A satisfactory outcome occurred when her concerns and symptoms were put into the context of her own upbringing. This could merely be due to there being enough resources to fund appropriate specialist staff and not because of any seismic shift in thinking away from today's psychiatry. Perhaps a better description of postpsychiatry would be "properly funded psychiatry."

It is also important to remember that not everything can be explained by social circumstances. Attempts by modernist

sociological psychiatry in the 1960s to do this led to the mismanagement and undue suffering of large numbers of core psychiatric patients. Speculations from R D Laing's era that mothers of people with schizophrenia and society at large were entirely to blame for their children's illness is a pertinent example. Modernist psychiatry, throughout the last century, was bound to unproved psychological and sociological theories. Biological psychiatry arose out of its failure to greatly improve people's care.

The authors' use of the term postmodern is mistaken, and the only evidence that they put forward to support this is by Muir Gray. We argue that this is a gross misrepresentation of postmodernism, a common occurrence when this word is used. We resent the use of the word as yet another buzz word.

Rather than losing ourselves in a philosophical discussion, however, we prefer to see the faults and failings in a grossly under-resourced service. Perhaps we should all be clamouring for more investment and, once this in place, see what needs changing and improving. We prefer to leave our intellectual power struggles outside the day to day care of the patients.

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Psychiatrists need different training for 21st century

EDITOR—Bracken and Thomas open what needs to become a vigorous debate about future directions in psychiatry, but I disagree with their arguments.¹ They claim that "20th century psychiatry was based on an uncritical acceptance of [the] modernist focus on reason and the individual subject." It is as if the major influence on the 20th century of Freud and his insistence on the role of desire, and not reason, as the wellspring of human action had never been and psychoanalysis had not been a major component in the practice of 20th century psychiatry.

The authors' focus seems to be narrowly Anglo-Saxon, as they fail to acknowledge developments in psychiatry elsewhere in Europe, such as the influence of Lacan, Kristeva, and Deleuze in France and Bassaglia in Italy. Indeed, they portray modern psychiatry as predominantly concerned with detaining people, and cite no references to studies of current psychiatric practice. The psychiatry I was taught and now practise in Scotland is all about working with patients in their social and cultural contexts and helping them manage complex social systems, including their families, employment, education, and the law.

Furthermore, the authors consistently and inappropriately assign agency to abstract concepts such as "psychiatry." Psychiatry does not have agency, but individual psychiatrists, in their daily prac-

tice, do. Such misplaced concreteness is particularly unfortunate in an article opposing instrumental rationality and hides the great variety of practice between individual psychiatrists. More fundamentally, the authors are unclear about their ontological and epistemological position and fail to explicate their schema for uniting empirical causality with hermeneutics. Lastly, sceptical caution is in order when placing service users centre stage. Clarke and Newman, for instance, argued that managers, wedded to a right-wing capitalist ideology, use the need of the consumer to break up state monopolies.²

Bracken and Thomas raise important points. In particular, far more attention needs to be placed on a sound understanding of ethics and the philosophy of science in the training of psychiatrists. This would allow practising psychiatrists to have the conceptual apparatus to engage in a moral science of action appropriate to a multicultural Britain of the 21st century.

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Authors' reply

EDITOR—Any call for a radical rethinking of an established discipline inevitably invokes a wide range of responses. Some are simply defensive (and sometimes offensive) dismissals, but others offer more considered objections and arguments. We direct our response mainly to the latter. In a brief reply such as this we cannot address individually every point our critics make. We have therefore put down a few thoughts here, which we hope will clarify some areas of misunderstanding, and hope to produce a book on the theme in the future.

"Postpsychiatry" is meant as a rhetorical device: a way of challenging current thinking, an invitation to imagine future possibilities, an indicator that radical change is already under way. In short, our aim is to provoke a serious discussion about the theoretical underpinnings of mental health work in the 21st century.

Having spent many years "dabbling in the history of ideas," we are well aware that the term "postmodern" is a nebulous concept. It is often used simply to refer to a contemporary social, cultural, and political condition, something we find ourselves in the midst of, the result of an economic shift towards a "more flexible mode of capital accumulation."¹

But postpsychiatry also emerges from another, more positive, sense of the postmodern as a way of reflecting on the world and our place in it. The last quarter of the 20th century witnessed a serious interrogation of the legacy of the Enlightenment and an increasing realisation that science and technology would not solve all the problems we face as humans. This was not, as some of

our critics seem to believe, an attack on science or the Enlightenment but a clearer realisation of their assumptions and limits. For us, postmodernism is about facing the contradictions and difficulties of our situation as humans without recourse to doctrines that assert that there will always be correct and incorrect ways of understanding, acting, and behaving.

This is not a new theory to replace Marxism, science, or religion but a deeper sensitivity to the ways in which knowledge, power, and values are interwoven. Perhaps postmodernism does raise more questions than answers. But we do not find this a frightening prospect. Rather, it seems a more mature and honest response to the social and moral issues we face than the dogmas that brought so much suffering to the 20th century.

The result of this is not therapeutic cowardice (Collinson and Morgan's view) but an openness to different frameworks and perspectives. Hence we welcome the emerging service user movement, which offers far more exciting and radical possibilities than simply existing as a pawn of consumerism, as van Beinum suggests.

Bagley asserts that service users are generally satisfied with the psychiatric status quo and simply want more of the same. This runs counter to our experience and the available evidence. In Rogers et al's large study of service users' response to the care they received, less than half found the attitude of their psychiatrist helpful ($n=463$).² *Knowing Our Own Minds*—user led research undertaken by the Mental Health Foundation—shows that most service users want far more than the traditional answers of psychiatry.³

We agree with van Beinum about the need to introduce a much wider curriculum in the training of psychiatrists, which over the past 25 years has become increasingly dominated by neuroscience.⁴ The responses of some of our critics (Ranjith and Mohan, Melichar and Argyropoulos) indicate the importance of this, and the need for a more sophisticated understanding of the relation between biological and social factors, such as that advocated recently by Rose.⁵

Far from leaving us in a position of paralysis with respect to a "determined agenda of the state" (Morgan), postmodernism (or postpsychiatry) actually allows us to see, and therefore to fight, injustice from more than one perspective. We struggle in very practical ways with the ideas that we propose; the home treatment service in Bradford is an example of this.

Another important focus for struggle is against the stifling influence of the pharmaceutical industry in psychiatric education and research. Collinson dismisses such concerns and argues that we should just get on with treating illnesses such as depression, which is said to be a global time bomb. Contrary to her assertion, we believe that this is exactly the sort of issue that requires a debate about knowledge, values, and power.

Should we be trying to frame all the sadness, misery, and demoralisation of different

peoples around the world in the technicalised, individualised labels of the *Diagnostic and Statistical Manual of Mental Disorders*? Will this be an advantage to anyone other than the drug companies, anxious to find new markets for their products? Should we not seek to engage with human distress in ways that put values such as solidarity, mutual support, and human rights centre stage? To echo Bagley, could it be a case of: they ask for social justice and we offer Prozac?

If psychiatry is to have a positive future it will require those of us involved in the specialty to be open to a radical questioning of our own theories and practice. This is not antisocial. Surely a truly scientific attitude is one characterised by questioning and doubt, not by dogma and dismissiveness.

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Synchronous chemoradiation for squamous carcinomas

This treatment is not gold standard for lung cancer

EDITOR—Tobias and Ball's comments on the management of lung cancer in their editorial on synchronous chemoradiation for squamous carcinomas were disappointingly brief and unhelpful.¹ Although some randomised trials have shown survival benefit from synchronous chemoradiation for patients with stage III non-small cell lung cancer, this is at the expense of increased toxicity. In a recent review of studies for non-small cell lung cancer by the Radiation Therapy Oncology Group Byhardt suggested that the "survival gains observed with some regimens may be negated by time spent with toxicity."² This is an important issue to which Tobias and Ball make no reference.

The authors also say that continuous hyperfractionated accelerated radiation therapy (CHART)—an effective and relatively non-toxic treatment preferred by patients—has "proved logistically too difficult for most departments"; they postulate that chemoradiation "will prove a more feasible ... way of achieving similar benefit." There is no direct evidence to support this conjecture, and it is as likely that the effects of continuous hyperfractionated accelerated radiation therapy and chemotherapy would be additive.

Chemotherapy would be inappropriate in a considerable proportion of patients with non-small cell lung cancer given radical radiotherapy. These patients are those with appreciable comorbidity and those with stage I or II disease who cannot be operated on because of medical reasons. They would benefit from continuous hyperfractionated accelerated radiation therapy.

Despite all the pressures of workload and machine shortages, about 10 centres in the United Kingdom currently offer continuous hyperfractionated accelerated radiation therapy to their patients. There is no good reason, apart from tradition, why all radiotherapy departments should not, like many other parts of the hospital, sometimes work in the evenings and at weekends; the additional costs are not great.³ Synchronous chemoradiation also has logistical difficulties and, undoubtedly, incurs greater costs.

As suggested in guidance from the Department of Health,⁴ the priority should be to implement continuous hyperfractionated accelerated radiation therapy. Then we can test whether conventional chemoradiation is as effective or whether combining chemotherapy with continuous hyperfractionated accelerated radiation therapy is even more effective.

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Changing management of oesophageal cancer will be difficult

EDITOR—We agree with Tobias and Ball that chemoradiotherapy with organ preservation should be initial management for patients with localised oesophageal squamous carcinoma.¹ As histology is not independently predictive of survival after chemoradiotherapy, the concept of primary chemoradiotherapy merits examination in adenocarcinoma.^{2,3}

A phase III trial of chemoradiotherapy versus surgery for oesophageal cancer is unlikely, nor is one really desirable. These should not be viewed as competing modalities—the issue is their optimal integration. Previous studies have revolved around surgery with or without chemoradiotherapy, with mixed results. Until recently, organ preservation was limited to patients unfit for surgery. No phase III trials have examined the role of surgery after definitive chemoradiotherapy.

Integration of "selective" surgery and primary chemoradiotherapy has been reported, with several criteria for surgery being used.^{2,4} Organ conservation rates of 92% and 58% in T1 and T2 cancers, and three year survival rates of 83% and 51% respectively, have been reported.⁴ Our experience of a 46% five year survival in squamous cancer suggests that planned selective surgery contributes to a superior outcome. However, this would require confirmation in a phase III trial. Primary chemoradiotherapy and selective surgery for patients with squamous cancer and adenocarcinoma had the important benefit of permitting organ preservation in 68% of long term survivors.⁵

To allay surgical concerns about operating after chemoradiotherapy we reviewed complication rates among patients treated either by surgery alone or after chemoradiotherapy.⁵ Time spent in hospital or an intensive care unit, rates of infection, chest drainage, anastomotic leaks, fistula, support with blood products, and mortality did not differ.

Effecting change in the management of oesophageal cancer is difficult, since referral patterns and treatments have historically depended on patients' fitness for surgery. The role of surgery now needs critical examination in both histological types of oesophageal cancer.

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Screening for type 2 diabetes

Undiagnosed diabetes must be detected

EDITOR—Early identification of type 2 diabetes is vital for the future of diabetes care, in terms of reducing the impact both on the individual and on NHS resources. Wareham and Griffin question the need for a screening programme because the benefits of early detection and treatment of undiagnosed diabetes have not been proved.¹ There is evidence, however, of the cost of treating the complications of diabetes, and

the United Kingdom prospective diabetes study has indicated how to reduce the risk of those complications through intensive treatment. Surely in the new, patient focused NHS, this evidence makes a compelling argument for providing that intervention as early as possible.

The authors suggest that clinical management of people in whom diabetes has already been diagnosed should be optimised before a screening programme is considered. This is unacceptable. Shouldn't everyone in the United Kingdom have an equal chance of effective treatment from the NHS? Are we in a position to say that patients lucky enough to have their diabetes diagnosed because of where they live, or because they are better informed on health issues, deserve greater priority than others who have had diabetes unknowingly for several years? Treatment must be optimised, but it must also be provided to all who need it.

Decisions about screening should be based on the best available evidence. Further evidence is required to identify how, who, and how often people should be screened, but this will take time. In the meantime we cannot afford to ignore the people with undiagnosed diabetes.

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Population screening was not effective in former East Germany

EDITOR—Before population screening for type 2 diabetes is initiated the effectiveness in reducing mortality and morbidity needs to be established. This should ideally be based on randomised controlled trial evidence, as requested by the National Screening Committee in the United Kingdom.¹

In the absence of such data, one may revert to the next best available evidence. In the former East Germany, Panzram et al ascertained complete cohort follow up data in one sociopolitical environment—sarcastically called a closed population.² They prospectively gathered clinical outcome data on a cohort of 250 diabetic patients who were diagnosed by population based glucosuria screening in Erfurt in 1963 followed by formal oral glucose tolerance testing. These patients were compared with 250 matched patients in whom diabetes was diagnosed after the onset of symptoms associated with hyperglycaemia.

According to the study protocol, the two groups were identical with regard to age, body weight, and sex distribution. All patients received continued diabetes care at the same diabetes clinic by the same medical and paramedical staff according to the structured programme for type 2 diabetes care as implemented throughout the former East Germany. This meant that the patients were seen by internist-diabetologists every one to two months and by an ophthalmologist annually.

Over the next 10 years mortality, causes of death, survival times, and the incidence of vascular complications were comparable between the two groups. This finding was confirmed at the end of a 20 year follow up.³ The authors concluded that the prognosis of type 2 diabetes was not improved by screening.²

The data from this case-control study with prospective follow up of cohorts obtained under extraordinarily rigid conditions of surveillance argue against the effectiveness of population screening for type 2 diabetes.

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Screening would have important resource implications for primary care

EDITOR—Wareham and Griffin conclude that there is no justification at present for universal screening for diabetes, but they support screening and intensive treatment in some population subgroups.¹ In June 2000 Diabetes UK recommended using the World Health Organisation's 1998 criteria for diagnosing type 2 diabetes.² This new diagnostic threshold, using a simple fasting plasma glucose concentration of >7.0 mmol/l, also provides a new category of impaired fasting glucose (6.1–<7.0 mmol/l), which classifies those at increased risk of developing diabetes.

We examined the prevalence of diabetes in older British men using the new criteria to ascertain the potential additional burden of diabetes requiring clinical management. In 1978-80 the British regional heart study randomly sampled and recruited 7735 men aged 40-59 from one general practice in each of 24 British towns. During 1998-2000, 4252 men (77% of survivors, now aged 60-79) were re-examined. All men known to have diabetes were excluded from the analysis (n=261). Men who failed to provide a blood sample or to indicate a fasting time (n=249) and those who failed to fast for over six hours as requested (n=491) were also excluded.

Among the remaining men (n=3251) 194 (6.0%) met the new criteria for type 2 diabetes and a further 604 (18.6%) fitted the category for impaired fasting glucose. In the subset of men who fasted overnight for over eight hours, consistent with the World Health Organisation's protocol, the findings were similar: 171 (7.4%) had undiagnosed diabetes and 481 (20.8%) had impaired fasting glucose.

The prevalence of undiagnosed diabetes and impaired fasting glucose among older British men is high. If the new national service framework for diabetes advises that

patients with impaired fasting glucose require individual clinical management this would have important implications for resources devoted to primary care.

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Authors' reply

EDITOR—Streets argues that a national screening programme for type 2 diabetes should be started on the basis of evidence available now. We agree with Cochrane and Holland, who argued that the level of evidence required to start a screening programme should be high because of the ethical difference between offering screening to populations and responding to demands for care by individuals.¹ Our comparison against the National Screening Committee's criteria allows policymakers to judge whether the current evidence meets this high standard. It also allows research weaknesses to be identified and helps inform the design of future studies.

We agree that additional evidence is needed about who to screen and how. The main unresolved question, however, is whether early detection results in net health benefit, given uncertainties about the magnitude of both the benefits and possible harms of screening. These issues highlight the need for randomised controlled trials of screening. Berger describes a comparison of two cohorts, one detected by screening and the other by clinical diagnosis. The inference that screening did not materially affect prognosis is limited by the nature of the study design and the possibilities of bias. We agree that the effectiveness of screening in reducing mortality and morbidity needs to be established and should be a major research priority.

Streets questions whether clinical services for people with established disease should be optimised before screening is begun. Recent reports indicate the potential for improving care in diabetes.² Optimising care for people with known disease is an important end in itself. If a screening programme for diabetes was considered it would be important to ensure that the service could meet the increased demands for diagnostic investigation and treatment.³

One of the main arguments against universal screening for type 2 diabetes, as Walker and Thompson point out, is that it would detect many individuals with lesser degrees of hyperglycaemia. Evidence suggests that intervention in these hypergly-

caemic states can reduce progression to diabetes.^{4,5} Although these studies reinforce the message that type 2 diabetes is preventable by dietary change and increased physical activity, they do not imply that targeted intervention in individuals with non-diabetic degrees of hyperglycaemia is the optimal approach to primary prevention.

Universal screening would result in the attribution of disease labels to large groups, to whom dietary and physical advice might be targeted. Rather than advocate this it may be preferable to concentrate on true population-level interventions, as secular changes in these lifestyles are societal rather than individual problems.

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Cataract surgery in very elderly patients

Biological age is more important than chronological age

EDITOR—Wong's article on the effectiveness of cataract surgery in elderly people contains an emphasis on chronological age and final visual acuity as a measure of success.¹ Wong does not mention the importance of biological age of individual patients and pays little attention to the potential improvement in daily functioning associated with cataract surgery. These are important factors when considering patients of any age for cataract surgery. But they are difficult to measure quantitatively and difficult to investigate; consequently they are not easily shoehorned into guidelines or health policy. A visual acuity of 6/12 or better is generally taken as a successful outcome in most studies in this area, and Wong applies this assumption to very elderly people. Very elderly people are, however, two to three times more likely to start with severely impaired vision (acuity of 6/60 or worse).² Depending on an individual patient's circumstances, a final postoperative vision of 6/18 may still be a good result, with improvement in ability to perform activities of daily living.

The benefit risk analysis for cataract surgery varies for each patient. Wong cites work by Armbricht et al,³ which has shown that elderly patients with moderate cataracts and mild age related maculopathy benefit more

from cataract surgery than patients whose pathology is vice versa. This is common clinical sense and applied daily by ophthalmologists who are not familiar with this research. The importance of assessing the needs, risks, and potential benefits of cataract surgery on an individual patient basis means that guidelines are difficult to formulate. The decision on whether cataract surgery is appropriate depends on the clinical assessment by the examining surgeon, and discussion with the patient. Any ophthalmologists, or other healthcare professionals aspiring to do cataract surgery, must be prepared to use clinical acumen and take the responsibility for reaching the decision to operate themselves. Attempts to include chronological age as a factor in healthcare policy, or guidelines on management of cataract, are bound to founder.

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Outcome of cataract surgery is poor in developing countries

EDITOR—The article by Wong gives useful information about cataract surgery outcome in developed countries, suggesting that the visual outcome of cataract surgery is generally likely to be good in these countries.¹

The outcome of cataract surgery in developing countries, by contrast, has been reported to be quite poor, with about a quarter or a lot more of the eyes blind after cataract surgery (presenting visual acuity less than 6/60) in population based surveys from China, India, and Mali.²⁻⁴ Most blindness worldwide is in developing countries, and cataract continues to be the leading cause, with about half the blindness attributed to it. For example, on the basis of recent population based data it is estimated that of the about 1 billion people in India, 18.7 million are blind, with presenting visual acuity less than 6/60 or visual field less than 20° in both eyes.⁵ This includes 8.2 million people blind owing to cataract and another 1.3 million blind after poor quality cataract surgery.

The recent evidence of the widespread poor outcome of cataract surgery in developing countries suggests that as much effort is now needed to improve the quality of cataract surgery in these countries as to increase the number of surgical procedures—if blindness due to cataract in the developing world is to be reduced substantially. This issue assumes particular importance in the context of a recently launched global initiative, "Vision 2020—The Right to Sight," to eliminate avoidable blindness worldwide by 2020.

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"Old age" can be appropriate on death certificates

EDITOR—I cannot let Kafetz's assertions that "old age" should not be acceptable on death certificates join the growing list of ex cathedra statements arising from the actions of one wayward practitioner [Harold Shipman].¹ One of the roles I still consider I have as a general practitioner is to protect my patients from overzealous investigation, which can be their lot when they cease to be an individual and become a diagnosis, or rather the quest for one.

I do not regularly use old age as a cause of death when certifying, but I think that it is entirely appropriate when, after a period of progressive decline, often over many years, an older person succumbs to the inevitable consequence of being born. In many cases the commonly used option of some form of pneumonia lends only a spurious diagnosis in the absence of any pathological correlate.

Each year I have several older patients who decline investigation or hospital referral (or whose family and carers do so on their behalf), believing that they would not wish to undergo the treatment for any of the potential diagnoses that I, or they, have considered. Such decisions are never reached lightly. No doubt in many cases it would be possible to reach an accurate diagnosis. Although this may have settled my intellectual curiosity and protected me from the attentions of the new agency, I think that this would have been achieved at the expense of quality of care for a human being. I also think that in such circumstances a postmortem examination would not address any public interest and would be counter to the intention of ante mortem care.

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Rapid responses

Correspondence submitted electronically
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